Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MRI CENTRAL HOUSTON
PO BOX 601449
DALLAS TX 75360

Respondent Name

GRAY INSURANCE CO INC

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-08-5038-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Workers Compensation Verification Form adjuster Brady Moulder authorized R&N 1st MRI approved. Therefore being given approval for treatment on this patient workers comp carriers are required by law to pay the provider for these services. Accident details-'MP. 99 Cresol-from Phenol (Acid) leaked out of a pipe onto [Claimant] head & face."

Amount in Dispute: $932.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reviewed our file. Our records reflect that Mr. Robert Wallace was contacted for authorization to perform the MRI. Mr. Wallace advised that the first MRI did not require pre-authorization. Furthermore, his notes reflect that we would not give voluntary authorization. He also noted that the provider was advised that the bill and report would be subject to retrospective review to determine if the procedure was reasonable and necessary." "[Claimant] sustained a very minor chemical burn to the right side of his face. He subsequently claimed chronic headaches that he related to post-traumatic stress disorder. The carrier denied this claim. A Contested Case Hearing was held on July 15, 2004. The Hearing Officer issued a Decision and Order concluding that the December 2, 2003 accident did not include post-traumatic stress disorder. Accordingly, it would appear that the carrier is not responsible for this bill. "

Response Submitted by: The Gray Insuarnce Co., 1717 East Loop, Suite 333, Houston, TX 77029

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2004	CPT codes 70553, A4927, 90782	$932.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 9, 2004
   - R-Payment denied prior to final adjudication since carrier is disputing that treatment/services is related to the compensable injury.

   Explanation of benefits dated April 5, 2004
   - O-Previously recommended amount has not been changed.
   - R-Payment denied prior to final adjudication since carrier is disputing that treatment/services is related to the compensable injury.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The respondent denied reimbursement for the disputed services based upon "R-Payment denied prior to final adjudication since carrier is disputing that treatment/services is related to the compensable injury."

   28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution.

   The Division finds that on March 3, 2004, the insurance carrier submitted a Notice of Refused or Disputed Claim stating "Carrier is denying any inj except for the superficial wound to the ee face (rt side) this denial includes treatment for anxiety, depression and any other mental illness or alleged injuries/illness."

   The July 15, 2004 Contested Case Hearing decision found that the compensable injury did not include post-traumatic stress disorder.

   A review of the submitted billing indicates that the disputed treatment was for the diagnosis code 784.0 – Headache. Based upon the March 3, 2004 Notice of Refused or Disputed Claim, the carrier denied any injury other than the superficial wound to the claimant's face.

   The requestor did not submit a copy of the MRI report or any medical documentation to support the billed service was for treatment of the superficial wound to the claimant's face; therefore, the Division finds this dispute may have unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute.
2. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the disputed treatment was for the compensable injury. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		4/10/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.